professional opinion as to whether Ms. Clark was a candidate for confirmation surgery because you had not seen her in 22 months?

A I don't recall, but that would be something that I could see myself saying that -- that I had outlined, you know -- as you established, I had outlined a kind of pathway to reevaluation, and that whole case was so delayed so that almost two years later they asked me the questions so -- and I didn't know what happened to Ms. Clark in the last 22 months.

Q What is it that makes you feel comfortable rendering an opinion as to whether Autumn is a candidate for confirmation surgery when you have never seen her if you could not make that determination for Ms. Clark because you had not seen her in 22 months?

A Did I state that there is -- that this person should not have sex reassignment surgery in my report?

Q Do you believe that Autumn should have a pathway available to potentially obtain confirmation surgery in the future?

A I would say that any long-term inmate who identifies as transgender and who thinks that

gender confirmation surgery is desirable for her ought to have a pathway to a psychotherapeutic, conversational trusted -- with a trusted person -- pathway over time to think about this question and to recognize her own ambivalence so that when -- so that she can, in fact, consider multiple things including her background and in this particular case her masochism, her self-hatred, her continued difficulties in interpersonal relationships, and so that I think that a -- that almost everybody deserves an opportunity to think about this over time, over a long period of time, with a trusted person when they can get at the forces, the motivations, for their wish for surgery, their hope for benefits, and their knowledge of the potential harms and the possibility that science would dictate that not everybody achieves their benefits, the desired benefits. So that is a pathway, and in that sense, my answer to your question is yes.

Q Do you understand that the Indiana statute that we have challenged in this case makes that pathway unavailable for transgender inmates within the Indiana Department of Correction?

A Yes. I now understand that, but the path -- what --

Q That's all I wanted to ask, Doctor. Thank you.
A It's not quite accurate, though.
Q Okay. I am just about done with asking my questions, I think. If it's okay with you, Doctor, I would like to take a break, maybe ten minutes or so to speak with my cocounsel.

And, Alex, I really think I'm very close to done if you want longer to speak with Dr. Levine or anything.

MR. CARLISLE: Okay.

(A discussion was held off the record, and a brief recess was taken.)

Q Doctor, despite the fact that my cocounsel has temporarily left the room and is now back, I have just two very quick follow-up items for you. The first, the Texas inmate that you testified about in the Norsworthy case, the California case, do you recall that inmate's name?
A I was never given a name. I have probably initials. I want you to know that --
Q And I'm sorry, Doctor. You answered the question. Who gave you that inmate's initials?
A The person who presented the case to me gave me a sheeted -- a printed sheet, rather, with the elements of the presentation. I happen to -- for

reasons I don't understand, I happened to have saved that and spoke -- it's always funny to me that the judge said that I fabricated this, and I have in my possession the basis for which I wrote in that case.

Q And you indicated that the individual had received gender affirmation surgery while incarcerated in Texas? Do I have that right?

A It was my understanding that -- maybe there was some confusion here about vaginoplasty. It was my understanding that this person was in prison for one reason in Texas and had castrated himself. He took off one testis, and he was sent to the hospital, and the naive surgeon heard that he did this for this reason, and he said, let's just finish the job. And so then they took off -- they took both. They took the other testis off.

Q Okay. So you don't even know if that person carried a diagnosis of gender dysphoria?

A Well, the patient said that he had gender dysphoria, you know.

Q But you don't know if they carried the formal diagnosis?

A Look, if you want to go downstairs and pull out the form --

Q I just want to know as you sit here today, do you know if that person had a formal diagnosis of gender dysphoria?

A Well, the -- when the person was transferred to the California institution because the person was known to -- I think had gender dysphoria and had this operation -- I don't know whether they did a vaginoplasty or not. At this moment, I don't know. But the person was housed in the female prison, and that's why they were consulting me because the patient said that she/he didn't know who he was, whether he was a man or a woman and was a behavioral disturbance, and nothing that the mental health professionals had done had calmed this person down. And so it was presenting to the great expert, Dr. Levine, who was coming from California -- coming from Ohio to tell them what to do with this case.

Q Were you consulted by Texas officials or by California?

A No. No. This was only in Sacramento. This is only for one hour. This whole problem started because I mentioned this in the Norsworthy expert opinion report.

Q Okay.

A That I wasn't sure that, you know, these people will live happily ever after, and that was my, quote, fabrication.

Q Okay. I am sharing with you what I have marked as Exhibit 48. Do you see that on your screen right here?

A Yes.

Q At the beginning of your deposition, Doctor, you had mentioned that in the lead up to today's deposition you had read an article by Van der Sluis?

A Yes, this is the one.

Q And others. Is that the article?

A And what?

Q I said Van der Sluis and others?

A Yes. Yes.

Q This is the article that you reviewed in advance of today's deposition?

A Yes.

MR. ROSE: Okay. I have nothing further. Thank you very much for your time, Doctor.

MR. CARLISLE: Gavin, I think that should be 49.

MR. ROSE: Alex, I sent you 48, but I never used it, so you can discard it, or I was trying to

make it so we did not have gaps in our numbering.

MR. CARLISLE: Okay. So can you send me the new 48 then?

MR. ROSE: Yeah. I'm so sorry. We just pulled this during the deposition.

MR. CARLISLE: Okay. Perfect.

CROSS-EXAMINATION

BY MR. CARLISLE:

Q Dr. Levine, how are you doing?

A I'm pretty good.

Q Good.

A It's 2:00.

Q It's 2:00 so we'll --

A I'm a little fatigued. I'm fine.

Q All right. Doctor, I want to start with earlier when you were talking with Mr. Rose you were discussing the clinician's role in determining whether the patient is telling the truth before you were cut off. Do you recall that?

A Yes.

Q What did you want to say before you were cut off?

A I wanted to say that in our -- in the international group's involvement in transgender care which largely decide who should have surgery and who should not, we encounter -- we had, in our

professional understanding of the differential diagnosis of someone who was requesting hormones and surgery, we had this concept of the true transsexual. The true transsexual is a term derived from Harry Benjamin, who is the father of this whole field. In 1966 he thought he could distinguish varieties of people who should have and shouldn't have surgery, and he called a couple groups of people true transsexuals. But, we, listening to Dr. Benjamin, we believed that there were true transsexuals, that is, people who should have and would automatically benefit from surgery. We kept that concept going for about 15 years. The trouble is that we discovered during the course of our work in the '70s and '80s is that many of the people sounded alike in their history, and they sounded just like Harry Benjamin's descriptions. They sounded just like the early chapters in psychiatric textbooks about transsexualism.

And we came to realize based upon confrontation with these patients and then confessions that they were lying about their history. Their history was, in fact, much more variable from one person to another, and this homogenous background was, in fact, false. And so

we stopped using the term "true transsexual," and so that's what I wanted to explain, the reason why it's not just making the diagnosis in the psychiatric evaluation. It is to make an assessment about the veracity of what we are told, so sometimes we want to get records from the community. Sometimes we want to talk to the parents. We often want to talk to the parents, and we want -- if there's a wife involved, we want to talk to the wife. So it's not simply like the diagnosis exists, and therefore the treatment has to be given of X, Y, and Z, but their responsibility, the evaluator's responsibility, is to judge over time and not just one time, you see, to judge over time the veracity of the history and how much does that change over time. And it often does change over time, and that's why we think a comprehensive psychiatric evaluation cannot be done in an hour or two hours. It has to be extended over time. That's what I tried to say.

Q Okay. In paragraph 44 of your complaint, do you recall discussing the 75 percent figure from the Littman article?

A Yes. I was extrapolating. The 75 percent actually should have been 76 percent from her statement that

only 24 percent of people went back to the original provider to tell them that they think they should transition, unfortunately. That was the source of the 75 percent. I should have said 24 percent returned in at least the study of 100 people.

Q All right. But that figure -- (inaudible)

A I'm sorry. That got jumbled.

Q Earlier you and Mr. Rose were talking about Exhibit --

MR. ROSE: Alex, I'm sorry. You have a bad connection or something. You're really choppy.

MR. CARLISLE: Let me try turning my video off.

MR. ROSE: That's much better.

MR. CARLISLE: Better with the video off?

MR. ROSE: Yeah.

MR. CARLISLE: Okay.

Q Sorry about that. Dr. Levine, earlier you were talking with Mr. Rose about Exhibit 37, the Cecilia article. Do you recall that?

A Yes.

Q You began to discuss why she was courageous, the author of that article. Can you explain what you wanted to say before you were cut off?

A Yes. To me and many other people, this was a key

article of breakthrough history of trans care. You see, in 1993 was the first presentation of a review of a large number of surgical -- the results of a large number of surgical experiences primarily Europe, and there was a 70 percent loss to follow-up rate, but nonetheless, the Faflin and Yungi (phonetic) concluded that surgery was an effective treatment, and there was no control, and the idea that you lost 70 percent to follow-up, you didn't know what happened to them, and then you made this conclusion that among the 30 percent, the patients generally without any particular measurement because there wasn't that kind of stuff back in the '80s and '90s, that sex reassignment surgery was really a good treatment.

So along comes, almost 20 years later, Cecilia and colleagues' study, and the study was of everyone who has sex reassignment surgery, and the data was not on self-report. The data was on the -- from the national databanks for criminality, for death, for psychiatric hospitalizations, for cancer incidents, and for suicides -- and for suicide and for suicide attempts. So in 2011, she presents this study, and it's free access, so anyone -- there's no pay wall. Anyone can read it

who was interested in the study. And it was really impressive that we had data, not subjective data but objective data on these many parameters, and she showed a ten-year graph about the death rate of various people who had sex reassignment surgery, right, and then she gave the causes for it, although she didn't use AIDS as a cause, interestingly enough. And so she showed that there was not only elevated suicide rate that Mr. Rose was asking me about, but there was elevated death rates, in general. There was elevated suicide attempt rates and elevated arrest rates. What I want to emphasize is that Cecilia and colleagues recommended in that article that these people after sex reassignment surgery, which, remember for the last 20 years was thought to be a cure of the problem, she recommended life-long psychiatric care after gender -- sex reassignment surgery, see. So this was just an amazing development in the scientific world of trans care, an ideal 30-year-follow-up study, you know, and with data that's objective. She presented this paper at the WPATH meeting, and the following year the 7th Standards of Care came out and didn't even mention this study. And so what we have here is an

introduction to the fact that the people who were promulgating and advocating sex reassignment surgery for people weren't paying attention to Cecilia and her crew. And so that's why it's a major study, and that's why I think all of us need to take our hats off to Cecilia and her group and to recognize despite what she might have said, don't interfere with sex reassignment surgery. Don't think this study shows what I think it shows, right? I think we all need to understand what's in the study. So when I educate people about transgender care, I have them read this study. See, it's not what Dr. Levine says. It's what the study shows.

So that's what I was cut off from saying, my great respect for Cecilia and her work, you see, and my disagreement about what that study meant in terms of caution. And, I mean, everyone has ignored her recommendations that these people have life-long psychiatric care afterwards. And so when I hear somebody saying, oh, this is a cure for gender dysphoria, I think, well, they didn't read the study, or they didn't remember what Cecilia and her colleagues said, life-long care. That means that they were mentally -- they're still not

mentally well, and they need more help than surgery can provide. That's what I wanted to say to Mr. Rose.

Q Very good.

A If he allowed me.

Q Dr. Levine, before our last break, you and Mr. Rose were talking about a pathway, and you indicated you weren't done speaking. What did you want to discuss before you were cut off about the pathway?

A I thought Mr. Rose was saying pathway meant that there should be sex reassignment surgery given to prisoners, and my concept of a pathway is different than his concept. My concept of a pathway towards sex reassignment surgery would be that if we knew someone wanted sex reassignment surgery who had this diagnosis, that we would enter into a process of talking over time, hopefully gaining the trust of the person, to review the motives for sex reassignment surgery, why they're in such distress, and why do they think the surgery will fix their distress when they only have genital dysphonia, for example, and that we need to think about what their hope for benefits are from the surgery and what the harms that they know about could come from it. And we need to teach them about what the state of

science is about this, you see, and we need to recognize that for Autumn, who's going to get out of prison one day, that this preparation while in prison is a pathway towards the eventual decision outside of prison to have or not to have sex reassignment, genital vaginoplasty. So the pathway is, to me, it's a psychological process that requires a trusted relationship to discuss a number of things to meet the legal criteria of informed consent. And, you know, when someone is involved in a lawsuit, they have to represent themselves as they have no ambivalence, but I can tell you as I have told many, many people, transsexual people are first human beings, and human beings are ambivalent about most major things in their life, but they don't necessarily represent their ambivalence.

When I talk about a pathway with a trusted relationship to a therapist, it's the therapist is going to teach this person that it's okay to be ambivalent. You can be worried about this. You could be frightened about this. You can have a panic attack about this and still decide in the future to have this surgery, but you need to understand what the anxiety, what the panic is about, you see. And we doctors can't tell you

because we don't have the scientific basis to tell you don't worry, dear, this will be fine. We can't say that, and we shouldn't be necessarily deliberately recommending surgery to people that we don't know in this way that you can only know in a pathway towards. A pathway doesn't mean that you're going to get there or that you actually will want to get there when you can get there, and so I think Mr. Rose was using the term pathway as a direct road to the operating table, whereas I think the pathway is the psychological process of thinking about one's life and one's future and trying to be realistic based upon science and based upon my desire and in understanding of the motivation for my desire because, see, people who are transgender or who meet the criteria for gender dysphoria have long been gender dysphoric. They have long been uncomfortable with their body, and suddenly relatively recently they suddenly want surgery.

And I want to know how you got from being comfortable taking hormones, you see, and feeling better about yourself and what is causing you to think this is the next step, and are you being manipulated by some legal process, you know, that

makes you say I have no ambivalence. That's what I wanted.

Q Thank you. Sir, given the state of science, is there a debate within the medical community that surgery -- as to whether surgery is a necessary or effective treatment option?

A There's considerable debate. You see, WPATH wants everyone to realize that -- wants everyone to think medical professionals agree that this is the right thing to do for these patients. But when I mentioned those two studies, the Branstrom, Pachankis, and Almazan and Keuroghlian study, what I wanted to emphasize, that these four people who are known from other publications to be staunch advocates for sex reassignment surgery, they said in the introduction to each of their respected papers that it's not clear what the mental health benefits of sex reassignment surgery are, or in this case, we talk about vaginoplasty.

But it's not clear what the mental health long-term benefits are. Now, these are not coming from skeptics. These are coming from advocates, so they undertook this study to prove that there was benefit. And, see, the Almazan study -- and Almazan is a medical student, I think -- the

Almazan study showed that there was no change -- that there was a decrease in suicidal ideation, but there was no change in suicide attempts, so to me these are kind of incongruent ideas. But the most important thing is not that study because that study has a long history of these -- this 227,000 people. Many very cogent methodologists have reviewed and trashed any of the studies that come from that population. It's the Branstrom and Pachankis study that we should talk about, you see, because they concluded that sex reassignment surgery had mental health benefits. They published that study online, I think, in December 2019, and immediately upon publication there were seven letters written to the editor by a total of 12 authors, and the editor is Ned Kalin from The American Journal of Psychiatry, and Dr. Kalin read these letters and decided to send that study out to two separate statisticians, methodologists. And because the seven letters to the editor says this is junk, the conclusions are not based on the data that is presented, and, in fact, one or two people suggested that the authors were being consciously dishonest.

The two independent scientists who looked at

this independently concluded that the data did not support the conclusions. Dr. Kalin then decided -- he wrote to the authors, and he said you must publish a retraction. So what I think -- so a little background for this. When a journal receives a paper, like The American Journal of Psychiatry received this paper, usually the editor sends it out to three different reviewers, and they must have read this article, and they said that you should publish this article, right? Then what happened happened, what I just described. You see, so what happened is that then the -- when this was published in print -- and that would be August of 2020 -- Dr. Kalin then wrote an editorial about what he did and what his concerns had been, and then he talked about the two statisticians. And he published the 7 letters by 12 authors, and he published the retraction of the conclusions by Branstrom and Pachankis, and what they agreed to is that more research is necessary to determine the mental health benefits of sex reassignment surgery and that they agree that their study did not answer all the questions that they thought it answered.

And so I tell you this long -- these multiple paragraphs I just uttered to say to you there are

doctors who are skeptical about this and doctors who are believers about this. And the state of science is uncertain. That's, of course, what the Medicare review in 2016 said and that, I think, prudent, intelligent, thoughtful people can disagree.

Now, in medicine, disagreement is common, and we use disagreement to articulate further studies, to design further studies to settle the controversy. In this field, we don't do -- we don't settle our arguments. We just sort of hate each other. We sort of have animus for one another. We select studies, so this state of disagreement here is so unlike any other medical issue, you see, and it should alert all of us there's something strange going on here where science is not respected by people. I think that's what I wanted to tell Mr. Rose.

Q Very good. Given the state of science you just described, are there treatment options for gender dysphoria currently available within the Indiana Department of Correction sufficient to treat prisoners with gender dysphoria even if surgery is not an option?

A As far as I understand, IDOC recognizes that this

is a particular psychiatric disorder and that it has accommodations that can be done to ease the pain and suffering and distress of people. And, you know, those are the things that WPATH has written about in SOC8, that is, that we should address them as they wish to be addressed with pronouns of her, you know, and if I say my name is Autumn, call me Autumn. They're called Autumn, right? They get the showers separately. They get female canteen items. They get evaluated and can obtain estrogen treatment, estrogen and puberty blockers, spironolactone. And they're generally accommodated very nicely to this, and hopefully all the things that they want make them temporarily feel better, you see.

So given the uncertainty about sex reassignment surgery having additional long-term, lasting benefits that prevent suicide and prevent depression and despair, you see, and given the politics that determine whatever state legislatures decide or the DOC decide, I think Indiana DOC is indicating that they recognize gender dysphoria as a problem. They recognize there's some things to do to make these chronically disturbed people -- many of them chronically disturbed people -- a

little more comfortable. And I think they make this a policy. And does that mean it cures all their distress about living in their body and living with their adversities and their crimes and so forth? No. But I think Indiana is trying to do something to help them, you see, within the limitations of the law, within the limitations of medical uncertainty. You see, even the fact whether hormones really improves males with gender dysphoria has not been adequately proven. It's just the fashion to do it, but the fashion of giving hormones which can be stopped and the body can -- at least the male body can return to some male function, is different than having a surgery that you can't reverse, you see, so I think that's one of the reasons why these DOCs easily provides hormones these days but don't easily provide sex reassignment genital surgery because of the irreversibility and the -- of the procedure. And the recognized -- the recognized vulnerabilities of these people because, you know, they have borderline personality disorder. They have self-harming behaviors. They are sociopathic. These are -- all these are indications that I don't cope well with life, with my feelings, and my

dilemmas, so I think the DOC is trying to treat these people, including Autumn. I don't think they're indifferent to Autumn's pain.

MR. CARLISLE: Very good. Thank you, Dr. Levine. That's all the questions I have.

REDIRECT EXAMINATION

BY MR. ROSE:

Q Doctor, I just have one very quick follow-up. Both with me initially and then with Alex you were discussing what we called a pathway to, however you want to phrase it, to gender-confirming surgery, to consideration for gender-confirming surgery. I don't want to -- I don't want anyone to get bogged down in semantics. In your estimation, in the appropriate patient, is it possible that this pathway could eventually lead to the provision of gender confirmation surgery for prisoners?

A For prisoners? Well, the answer is potentially yes.

MR. ROSE: Okay. Thank you. I have nothing further.

RECROSS-EXAMINATION

BY MR. CARLISLE:

Q Was there anything you wanted to add on that before we end today?

A Are you talking to me? Anything I wanted to add?

MR. ROSE: I'm going to object. That's not a proper question.

Q Were you done speaking?

A I'm sorry. I didn't quite understand. Were you asking me, Alex?

Q Yes, Dr. Levine. Were you done speaking?

MR. ROSE: Sorry, Alex. I asked a yes or no question and got an answer. If you have a real question, you can ask it, but that's not a proper question either here or in court.

Q Did you want to explain that answer?

A Oh.

Q It seems like you were about to speak. That's all I'm asking. If you don't, that's fine, and we can end. I just want --

A No. You know, I would be happy to elaborate that because, you know, the whole nature of the deposition is to force me to answer yes and no to things that are profoundly complicated. And I gather that's -- the purpose of that is for the trial. But the -- what I want to say is that theoretically there could be a person who is in prison who -- that the psychological pathway of ensuring informed consent and increasing maturation

and improving coping capacities of that person to deal with this life and recognizing the impact of the past on his present distress, you see, theoretically, it is possible that in a state that allows that like Massachusetts or California, that with the proper preparation, if the patient persists in requesting sex reassignment surgery, I think it's reasonable for that particular person. But that is different than all people with gender dysphoria ought to have a pathway to this, you see, to surgery. Mr. Rose asked me basically on a theoretical sense given the fact that I believe if a pathway exists, so I said yes, but I don't know how frequently that would happen given what I understand about the associated psychopathologies and the numerous adversities of these prisoners that I have seen over the 17 years working with prisoners have.

And if you recall the Osborne and Lawrence study, they too had a lot of criteria that had to be met before they would even consider it, but they thought it was -- they would have given the same answer that I gave to Mr. Rose. Theoretically there's a person who might have qualified for it and it would be reasonable but not most of them.

That's what I wanted to say. I think you guys are done with me.

MR. ROSE: I think so. Thank you for your time today, Doctor.

THE WITNESS: I hope you're hungry, all of you. Bye, everyone. Are you and I done now, Alex?

MR. CARLISLE: I have one more question. Do you want to review the transcript and sign off on it, or do you want to waive that opportunity? It doesn't matter to me.

THE WITNESS: I would prefer to waive the opportunity just because it's just too difficult, too boring.

MR. CARLISLE: All right. We will waive signature then.

THE WITNESS: Thank you.

MR. CARLISLE: That's all I have for you, Doctor.

THE WITNESS: All right. Good afternoon, everyone.

MR. ROSE: Take care Doctor. Thank you. And, Madam Court Reporter, you remember that we asked for a rush for this week?

THE REPORTER: Yes. So an electronic delivery Friday would be okay?

MR. ROSE: That's perfectly fine. Thank you.

THE REPORTER: That's no problem.

Mr. Carlisle, do you need a copy?

MR. CARLISLE: Yes, please.

THE REPORTER: E-Tran?

MR. CARLISLE: E-Tran is fine.

THE REPORTER: Do you also need it by Friday or just regular?

MR. CARLISLE: Just regular.

AND FURTHER THE DEPONENT SAITH NOT.

(Signature waived)
STEPHEN BARRETT LEVINE, MD

STATE OF INDIANA)
) SS:
COUNTY OF JOHNSON)

I, Gretchen Fox, RPR, a Notary Public in and for the County of Johnson, State of Indiana at large, do hereby certify that STEPHEN BARRETT LEVINE, MD, the deponent herein, was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in above-captioned cause.

That the foregoing deposition was taken on behalf of the Plaintiff remotely via Zoom videoconference on the 7th day of February, 2024, pursuant to the Applicable Rules.

That said deposition was taken down in stenograph notes and afterwards reduced to typewriting under my direction, and that the typewritten transcript is a true record of the testimony given by said deponent; and that the signature of said deponent to his/her deposition was waived by the deponent and all parties present, the deposition to be read with the same force and effect as if signed by him/her.

That the parties were represented by their aforementioned counsel;

I do further certify that I am a disinterested person in this cause of action; that I am not a relative or attorney of either party, or otherwise

interested in the event of this action, and am not in the employ of the attorneys for either party.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this _____ day of _____, 2024.

_____
Gretchen Fox

Commission Number 066154

My Commission Expires:
January 25, 2031

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